

123

LAW OFFICES OF

**DUKES, DUKES, KEATING & FANCA, P.A.**

2909 13<sup>TH</sup> STREET, SIXTH FLOOR  
GULFPORT, MISSISSIPPI 39501

WALTER W. DUKES  
HUGH D. KEATING  
CY FANCA  
PHILLIP W. JARRELL\*  
W. EDWARD HATTEN  
TRACE D. MCRAVEY  
BOBBY R. LONG

WILLIAM F. DUKES,  
(1927 - 2003)  
P. O. DRAWER W  
GULFPORT, MS 39502

TELEPHONE  
228-868-1111

FAX  
228-863-2886

\*\*\*\*

JE'NELL B. BLUM\*\*  
DAVID N. DUHE  
HALEY N. BROOM  
JON S. TIRER

September 11, 2008

\*also licensed in TX  
\*\*also licensed in CA

James B. Halliday, Esquire  
Attorney at Law  
P.O. Box 6783  
Gulfport, MS 39501

Re: In the United States District Court for the Southern District of Mississippi,  
Southern Division, Civil Action No. 1:07cv1238-LG-RHW  
Al-Khidhr vs. Harrison County, MS et al  
Our File No. 1811.0123

Dear Jim:

Please provide this office with copies of all documents and other materials listed in your Pre-discovery Disclosures. In the event there should be an expense associated with this request, please let me know as soon as possible.

Further, I am enclosing two Medical Authorizations (HIPPA), which I am requesting that you have your client sign and return to me at your earliest convenience.

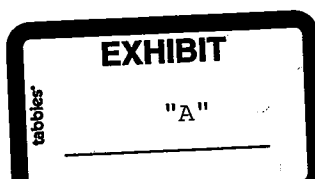
If you have any questions, please do not hesitate to call.

Very truly yours,

**Dukes Dukes Keating & Fanca, P.A.**

  
Haley N. Broom

HNB/rdh



**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

I hereby authorize \_\_\_\_\_ to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requestor Name: Dukes, Dukes, Keating and Faneca, P.A.  
P.O. Drawer W  
Gulfport, MS 39502

Patient Name: Only Al-Khidhr  
Patient DOB: 09/09/1951  
Patient Social Security Number: 587-41-1499  
Patient Address: 170 Hannible Court  
Biloxi, MS 39530

Disclose the following PHI for treatment dates (09/09/1951) to Present.

☒ Abstract/Pertinent      ☒ History and Physical      ☒ Physician Orders      ☒ Entire Chart  
☒ Operative Report      ☒ Progress Notes      ☒ X-ray      ☒ Billing  
☒ ER Report      ☒ Lab      ☒ Consult  
☒ Other specified      ☒ Discharge Summary      ☒ Nurse Notes  
☒ Other Specified: All other such records in your possession, custody or control.

The above information is disclosed for the following purposes:

☐ Medical Care      ☒ Legal      ☐ Insurance      ☐ Personal      ☐ Other

\_\_\_\_\_  
*initials* I acknowledge, and hereby consent to such, that the release of information may contain alcohol and drug abuse, psychiatric, HIV or genetic information

This authorization shall expire upon this expiration date: final disposition of Al-Khidhr vs. Harrison County, et. al or five (5) years from the date of this authorization, whichever comes first  
\*\*If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

- I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to \_\_\_\_\_. I understand that the revocation will not apply to information that has already been released to this authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date

If signed by legal representative, relationship to patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

## AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES

Name: Only Al-Khidhr

Date of birth: 9/9/1951

Social Security Number: 587-41-1499

I hereby authorize all health care providers, physicians, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals, pharmacies, Social Security Administration Disability Determination Services and Department of Workers' Claims, to release all psychotherapy note records and information regarding \_\_\_\_\_, to the records service of \_\_\_\_\_.

I understand that this authorization is for release of psychotherapy notes as defined by the Health Insurance Portability and Accountability Act 45 CFR 164.501 [*psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record*].

I, the undersigned individual am on notice that:

- Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.
- Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
- This authorization can be revoked through written notice to \_\_\_\_\_, or to the individual above listed entities, except to the extent that action has been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.
- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until settlement or final disposition of Al-Khidhr vs. Harrison County et al or five (5) years from the date of this authorization, whichever comes later.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature) Patient or Patient Representative

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Description of Representative's Authority to Act for the Patient

**This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.**

**\*Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress date.**